GEORGIA'S

Consumer-Driven Road to Recovery

A Mental Health Consumer's Guide for Participation In and Development Of Medicaid Reimbursable Peer Support Services

DHR

Division of Mental Health, Developmental Disabilities and Addictive Diseases
Office of Consumer Relations
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Dedication

This manual is dedicated to all members and the staff of The Peer Project, Peggy Small and Will Mondi, CPS. It is such a pleasure to work together with these folks as we forge new territory for our consumer operated Peer Center. They reinforce for me daily, the very real power of peer-to-peer support. Thank you for your patience and support while I worked on this manual.

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Introduction

Mental Health Services in the State of Georgia have undergone significant changes since July 2001. The Division of Mental Health, Developmental Disabilities and Addictive Diseases, which oversees the funding and contracting of mental health service providers, has, at the Governor's request, made two major shifts in services. One of these services has to do with the way providers bill for and receive compensation for providing mental health services to you; this is known as Revenue Maximization (RevMax). The other shift has to do with the orientation of how services are delivered, a Medicaid recovery model called "The Mental Health Rehabilitation Option" (Rehab Option). These two initiatives were introduced at the same time, but they are very distinct. One is a way of *funding* your services and the other promotes *delivery* of recovery services.

The purpose of this booklet is to explore how these shifts impact us, the Mental Health Consumers of Georgia. We will also look at some of the new statewide programs that have come to pass as a result of these shifts. You may be familiar with some of this information and some of it will be brand new. While we will try to avoid the use of a lot of technical jargon, we will introduce some of the terminology that will make it easier to understand and talk about your services. There is a resource list at the back of this booklet that will give you contact information for various leaders and ways to research in depth any topic you might be particularly interested in.

Georgia Mental Health Consumers played a vital role in the decision making and planning of these new services that support your recovery. The goal of these changes is to improve the services we use. Consumer input helps insure that our needs, priorities and issues were considered at every step. Whenever there is change in a system as large as ours, it takes time to get everyone trained and on-board. Service providers have been receiving new training. Administrators have been receiving new training. And, as the most important part of this new system, we the consumers need access to new training. This booklet is a part of that training. We need to know what is going on. So, now it is our job to educate ourselves about why these changes were made, how to benefit from these changes, and to know our roles.

We will explore Medicaid Services and the Rehab Option as it supports Self-directed Recovery. We will look at the expanded growth of Peer Supports as a result of these changes. We will look at the impact of the Consumer Operated Peer Center and ways to ensure the success of this new kind of programming. We will outline the development and growth of the Georgia Peer Specialist Certification Project and the

role of consumers in service delivery. We will identify the need for greater involvement of consumer leaders and how the Georgia Peer Support Institute supports this. We will also identify the critical involvement of each of us in our own treatment planning through the use of our Individualized Service Plan.

This is a manual written *by* Mental Health Consumers *for* Mental Health Consumers, which is the peer-to-peer philosophy in action. We are able to and should educate one another. We can be our own best leaders. This is your manual. Share it with your friends and family. Share the knowledge of how to best be active in your own recovery. This is an empowerment tool, a resource to help us navigate the mental health system and a guide to know what we can and should expect from that system. This is an aid in helping each of us become personally responsible for directing our own recovery.

These are exciting times in our State. Restructuring the mental health system means we must pay close attention to all the new changes and possibilities. We must know that there is no treatment team without our involvement. There is no peer support without our participation. There is no better expert of our life and recovery than us. It is time to get involved.

"The consumer movement has increased the involvement of individuals with mental disorders and their families in mutual support services, consumer-run services, and advocacy. They are powerful agents for changes in service programs and policy.

The notion of recovery reflects renewed optimism about the outcomes of mental illness, including that achieved through an individual's own self-care efforts, and the opportunities open to persons with mental illness to participate to the full extent of their interests in the community of their choice."

Mental Health:A Report of the Surgeon General
Executive Summary – 1999

There is a revolution brewing in the field of severe mental illness…. [It is] a revolution that is beginning to occur right now. It is a vision – in what is believed to be possible for people with severe mental illness…. It appears that it will be up to consumers and their family members to lead this revolution in vision – to guide or drag professionals toward the 21st century.

William A. Anthony, Executive Director
Center for Psychiatric Rehabilitation
at Boston University

Section One: The Beliefs

The Recovery Model

The Recovery Model for mental health services is one that embraces the idea that people can and do recover from mental illness. To support this goal, all treatment interventions are planned and carried out in a real partnership that occurs between the mental health consumer and their treatment team members. The model challenges old assumptions and creates new beliefs about treatment and recovery.
One advocate who serves as a teacher for both consumers and staff, Ike Powell, Director of Training for the Mental Health Empowerment Project, Inc., explains the Recovery Model by discussing the difference between established practices and emerging practices. The established practices are generated by what is commonly referred to as the Medical Model (previously promoted heavily under Georgia's Clinic Option) and the emerging practices are the basic premises of the Recovery Model. One way to compare these models is to look at a side-by-side table. *(See Table A)*

The Recovery Model is more than just a change in language or jargon. The goal is for a real fundamental shift to occur in the way all of us think about treatment or what we believe about recovery from mental illness. One of the most important things to know is that this Recovery Model does not just mean that providers change how treatment is provided, but that we as consumers change the way we participate in treatment.

For those of us who are mental health consumers, this means we need to learn about self-directed recovery and, perhaps, come up with our own working definition of recovery. For some people, recovery may mean being symptom-free and off medication. For someone else, it may mean taking medication to help with symptom management. Another may define recovery as experiencing improvement in the quality of the life he or she lives. For still others, it may mean regaining purpose and meaning in their lives.

In 1997 the Canadian Mental Health Association conducted a consumer satisfaction survey in which consumers were asked what issues were most important in their recovery. The result was that people wanted "a job, a home and a friend." The Georgia Mental Health Consumer Network provides the consumers of this state an opportunity to vote each year on their priorities. Consistently, the top priorities have to do with wanting jobs… better jobs. This seems to be a way many of us measure the success of our recovery.

Once we know what our own definition of recovery is, we can more effectively form the necessary partnership with our treatment providers that empower us to reach our goals. When treatment was provided from the older, established practices of the medical model, we couldn't exercise much control over our treatment. The provider would create our goals, would plan our day, and "let us know" when we were ready for our next step. But with the Recovery Model, we become the leader of our treatment. We have the right and responsibility to name our own goals, influence the program around us, and participate in identifying what is helpful and what is not. By doing this, we become involved in self-directed recovery. We can determine our personal priorities. This kind of personal empowerment allows us to be more independent and more responsible for the choices in our lives.

Self-directed Recovery means we are making our own choices about pursuing an education, seeking paid employment, or participating in political or social advocacy. It means we make decisions about our physical, emotional, mental and spiritual health.

There are many positive outcomes about the Recovery Model and Self-directed Recovery, but perhaps the most important one is that we believe that recovery is possible for all consumers and that we should insist that the people we work with on our treatment team support this belief. We should expect that our mental health providers support personal empowerment and that we experience empowerment in making the choices regarding our own lives. We do have the right to choose where we will live, how we handle our finances, when and where we work, and to whom we disclose.

Table A

Medical Model	Recovery Model
Established Practices: Harsh restraint methods Sheltered Workshops Long term hospitalization Massive doses of medications Staff directed treatment	**Emerging Practices:** Consumer and family education Consumer-run initiatives Community-based care Medication to suit the individual Consumer participation in treatment Self-help groups Supported Employment
Established Task: Stabilization Custodial Care	**Emerging Task:** Education Involvement
Established Beliefs: Will never be able to function in society Impaired judgment & can't trust thinking Needs to be stabilized & cared for Has something wrong with them that someone else needs to fix Do not understand their own needs Will not recover	**Emerging Beliefs:** Can function well in society with supports Can make a positive contribution to society Can learn ways to cope with symptoms Can use experience of mental illness as a source of knowledge Can learn from and teach other consumers CAN & DO RECOVER
Established Responsibility of Provider: Will provide appropriate custodial care based on staff wisdom and input	**Emerging Responsibility of Provider:** Provide an environment that is conducive to recovery, based on consumer wisdom and input
Established Responsibility of Consumer: Be obedient and learn to comply	**Emerging Responsibility of Consumer:** Self-advocacy--dialogue with the system about what is and is not helpful Take responsibility for one's own recovery Use self-help

The Medicaid Rehab Option

When the State of Georgia adopted Recovery as the model for state-funded programs, it did so by introducing the Rehabilitation Option (Rehab Option). The evolution towards the Rehab Option began at a point in Georgia's history when there was a convergence of the consumer movement identifying recovery values as the State was addressing accountability questions about the appropriateness of service and outcomes and the development of current best practices. Public services had been utilizing the Medicaid Clinic Option, which was closely aligned with the Medical Model. Embracing the Medicaid Rehab Option allowed for true consumer-driven values, such as Recovery, to be integrated into all mental health services.

One way to picture this shift is to look outside mental health and explore the way some physical conditions are treated. Let's imagine for a moment that you have been in a car wreck. At the point of impact, both your legs are broken. Your legs are reset and the course of treatment then focuses only on pain reduction. Do you need more care than that? Yes! You would need to begin physical rehabilitation that would allow you to recover your strength and mobility.

So now, let's apply this rehab model to mental illness. Historically, the primary goal of treatment services has been to focus on symptom (pain) reduction using techniques like reliance on medications, staff directed treatment planning, and sheltered workshops. But a person with severe mental illness wants more than just symptom relief. They want recovery.

Rehabilitation Services have clear purpose, focus, and activities.

Purpose	Focus	Activities
Provides skills and supports to maintain and sustain independence.	The consequences of the illness and the rebuilding of a positive self-image.	Goal Setting Skills Teaching Resource Coordination Supports Development

The Rehab Option is greatly influenced by the Core Principals of Psychiatric Rehabilitation as recognized by the International Association of Psychiatric Rehabilita-tion Services (IAPSRS). If we as consumers are familiar with these core principles, we will better know what *our* role is in the Rehab Option and what our service pro-viders role is. The 15 core principals are:

1. Recovery is the ultimate goal of Psychiatric Rehabilitation. Interventions must facilitate the process of recovery.
2. Psychiatric Rehabilitation practices help people re-establish normal roles in the community and their integration into community life.
3. Psychiatric Rehabilitation practices facilitate the development of personal support networks.
4. Psychiatric Rehabilitation practices facilitate an enhanced quality of life for each person receiving services.
5. All people have the capacity to learn and grow.
6. People receiving services have the right to direct their own affairs, including those that are related to their psychiatric disability.
7. All people are to be treated with respect and dignity.
8. Psychiatric Rehabilitation practitioners make conscious and consistent efforts to eliminate labeling and discrimination, particularly discrimination based upon a disabling condition.
9. Culture and/or ethnicity play an important role in recovery. They are sources of strength and enrichment for the person and the services.
10. Psychiatric Rehabilitation interventions build on the strength of each person.
11. Psychiatric Rehabilitation services are to be coordinated, accessible, and available as long as needed.
12. All services are to be designed to address the unique needs of each individual, consistent with the individual's cultural values and norms.
13. Psychiatric Rehabilitation practices actively encourage and support the involvement of persons in normal community activities, such as school and work, throughtout the rehabilitation process.
14. The involvement and partnership of persons receiving services and family members is an essential ingredient of the process of rehabilitation and recovery.
15. Psychiatric Rehabilitation practitioners should constantly strive to improve the services they provide.

The Rehab Option creates a fundamental change in how services are provided and used. This shift isn't just an idea for people to think about; it is now a real practice. So, the Emerging Practices from *Table A* have now emerged. And so have we.

Recovery and the Rehab Option have to do with fundamental shifts in thinking and practice, but they also have to do with funding. Regardless of what types of programs are being offered, they must be paid for. Consumers in the public mental health system are billed for services based on their ability to pay. Some consumers may have private insurance, but most rely on Medicare or Medicaid to pay for services. The Medicaid Rehab Option is a way for the state to have Medicaid help pay for services. This option not only proposes a program that creates more flexibility for treatment and support services for people with mental illness, but also creates a way for the state to maximize money that is used for other initiatives.

According to a News Brief released by the Division of Mental Health, Developmental Disabilities and Addictive Diseases, ". . . the more flexible Rehab Option makes it possible to bill Medicaid for additional services offered outside of traditional clinics, such as intensive case management, assertive community treatment, and some components of residential services. These services go beyond stabilization to promote recovery – the treatment goal widely supported by consumers." The Rehab Option further supports the availability of previously Medicaid-supported services, such as peer support and day services.

In order for us to most effectively benefit from this shift, we must look at the ways we can participate in this system.

Section Two: The System

What is Medicaid?

Medicaid is a federal-state program, which means that both the federal government and state governments have input into how the program works. Because of this, Medicaid programs vary from state to state within broad federal requirements. Medicaid is also an assistance program. It serves low-income people of every age. Consumers who qualify for Medicaid do so because of their income or because of the cost of their treatment compared to their income. Federal Medicaid contributes approximately 60-cents of every dollar delivered for Medicaid recipients in Georgia. The State finances the remaining 40-cents.

Frequently when people talk about Medic*aid*, it is paired up with Medi*care*. This is because some people who receive one benefit will receive the other. But actually the programs are two very distinct programs. Medicare is an insurance program. So, much the way one pays for a private insurance policy, people who are gainfully employed pay into the Medicare insurance program. There are deductibles and co-pays just like with private insurance. People qualify to use Medicare if they become disabled or are over 65 years old. Medicare availability is not based on income, but rather what one has paid into the program through the number of years they had paid employment.

The "Rehab Option" is a federal Medicaid program for mental health and substance abuse services. Rules and guidelines associated with the program are very specific and require constant monitoring in order to ensure that the federal money continues to support consumer services. In addition to other types of services, the Rehab Option allows for reimbursable charges for Peer Services. These Peer Services can be provided in traditional provider settings or in a new provider category called consumer operated Peer Centers. *(See Section Three.)*

Often, states contract with independent organizations to provide what is called "External Review." In Georgia, the External Review Organization is a company called APS Healthcare, Inc.

The Role of APS

APS Healthcare, Inc. (APS) is Georgia's External Review Organization, which provides quality improvement services, provider training, and extensive management of services known as Utilization Management (UM). Their goal is to ensure that Medicaid eligible consumers are provided appropriate services to facilitate recovery. This is achieved by offering provider training and technical support, on-site audits, and a quality improvement process that includes the input of consumers, family members, providers, and state policymakers.

Utilization Review (UR) is a process that ensures a consumer is being served appropriately. These efforts support the overall mission of the Division of Mental Health, Development Disabilities and Addictive Disease and APS Healthcare (APS) to promote a system that ensures…

"The right consumer
In the right service
At the right time
With the right provider
At the right intensity
For the right duration
At the right price
With the right outcome."

These goals and their support of recovery based services help create a system that is consumer-driven and respectful. APS includes consumers as members of their Quality Improvement Advisory Council to advise APS regarding improving provider performance and Medicaid services. APS also has a Manager of Consumer Relations to work with the consumer community regarding the quality of services being provided and a consumer fills this position.

In a past issue of the APS Review (a newsletter produced by APS) a question is posed for discussion. The question asks, "What is the positive impact of Utilization Review on consumer care around the state of Georgia?" A part of the answer reads: "When consumers are served in the appropriate service and a provider utilizes the necessary interventions to facilitate change, consumers move toward increased independence and reliance on natural community supports. The foundation of Utilization Review is set when the consumer and the provider agree on meaningful goals."

APS needs not only a partnership with providers to ensure quality services are being delivered in Georgia, but it also needs a partnership with con-sumers. We are best able to impact this partnership by actively partici-pating in the creation of an Individualized Service/Recovery Plan (ISP).

My ISP

The Individualized Service/Recovery Plan (ISP) is a part of the Treatment Request and Integrated Georgia Reporting Survey (TRIGRS) that must be completed on all consumers who have Medicaid and are receiving services. TRIGRS is a treatment request form for authorizing Medicaid-billable mental health and substance abuse services in Georgia. TRIGRS helps to determine the medical necessity and rehabil-itative needs of a consumer. It ensures that each ordered service is appropriate to the goals and achievement of goals that the consumer requests.

TRIGRS is comprised of three sections:

1. Demographics – basic identifying information, diagnosis as identified by DSM-IVR codes, medications, and history of hospitalization.

2. Assessment – stressors, current symptoms, work involvement, skills/abilities, needs, commitment to treatment, and hopes/ recovery progress.

3. ISP – problem list and justification of service, transition/discharge plan, and therapeutic goal modules.

Basically, the ISP is a treatment plan. No ISP should exist without having direct consultation and input from a consumer. Let's take a closer look at the components of an ISP.

1. The Problem List is an optional item for some programs, but required by others. However, when it is used, it is helpful in
   determining the primary focus of treatment. As consumers of these services, it may be helpful for us to think about what it is that brings us to treatment and what our desired outcome is. This can create clarity for us and for the members of our treatment team. The Justification of Service ensures that we are involved in services that will actually meet our needs.

2. The Transition/Discharge Plan has three components: projected dates, anticipated "step-down" or decrease of intensity of services, and a statement of accomplishments needed to attain graduation.

3. The Therapeutic Goal Modules make up the most significant part of the ISP. It is in this section where consumers should come up with strategies for achieving recovery. Goals should be achievable, specific, and individualized. Objectives should be measurable and interventions should reflect how staff would assist or empower the consumer towards goal completion.

In *Appendix A* of this manual, there is an example of an ISP for a fictional consumer. While the person is fictional, the goals, objectives, and interventions are very real for many of us. Remember, when you are working on your ISP, it is your personal goals and desires that will determine your satisfaction with your treatment and your ability to embrace your own recovery. You are the leader of your treatment team!

Section Three: The Support

Exploring Peer Support

Peer support has always existed. People with common experiences have always benefited from sharing with and supporting each other. There is something about knowing that the one you are talking with has a personal appreciation of, or insight into, your experience. To narrow our focus, let's look at peer support as it directly relates to mental health and recovery. Our recovery comes from the insights we have about living with mental illness and how we managed the challenge.

There is a historical perspective to peer support that has led to the formalization of Peer Support. There have been many important milestones in this history. In 1999, David Satcher, M.D., Ph.D., released *Mental Health: A Report of the Surgeon General.* This most significant document references the work of pioneering consumer Patricia Deegan, Ph.D., who refers to Recovery as "… a *lived experience* of gaining a new and valued sense of self and purpose." Deegan is again referenced in her definition of Recovery as…

> "A process, a way of life, an attitude, and a way of approach-ing the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again…. The need is to meet the challenge of the dis-ability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution."

The Surgeon General's Report also asserts, "Mental health services continue to be refined and shaped by the consumer and recovery emphasis. The most tangible changes in services come from assertive community treatment and psychosocial and vocational rehabilitation, which emphasize an array of approaches to maximize functioning and promote recovery…Champions of recovery assert that its greatest impact will be on mental health providers and the future design of the service system."

A review of our State's growth towards Peer Support highlights several key milestones. If we were to look at just the last decade, we see a huge shift. One of the most significant milestones for the consumers of Georgia occurred over a three-year period, from 1991 to 1993. It was during this time that the Georgia Mental Health Consumer Network (GMHCN) was forged out of a small gathering of 30 or so people with the common goal of creating a unified voice for us. The group created a newsletter, which has since grown into the quarterly publication, *The Pipeline*. The formation of the

GMHCN also led to the State's development of the Office of Consumer Relations in 1993. The creation of this office ensures that the consumer perspective is represented in policy planning and decision-making at the State level. This office is a part of the Department of Human Resources' Division of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD).

Highlights of Georgia's Consumer Movement History

1991	GA Mental Health Consumer Network begins
1993	State passes HB100 (A law that recognized consumers critical role in shaping service.)
1993	GA Office of Consumer Relations opens
1994	GA Consumer Council developed
1997	Cemetery Restoration Project begins
1999	Peer centers open in GA
2000	GA Consumer Leadership Institute
2001	Dedication of the Restored Cemetery
2002	GA Peer Support Institute begins
2002	GA Peer Specialist Certification Project begins

At every step of the way, it has been the input and priorities of the consumers of Georgia that have influenced the growth and direction of each of these initiatives.

An example of how this has occurred can best be seen in the Cemetery Restoration Project. The Georgia Consumer Council, which serves as an advisory group to the Director of the Office of Consumer Relations, had gathered for a meeting on the grounds of Central State Hospital (Milledgeville) in March 1997. Upon the advice of consumers working at the hospital, the group toured the cemetery. It was an emotional and life-impacting tour for those who walked the grounds. Before them lay an ignored and dishonored cemetery. The members of the Consumer Council determined that they would take responsibility for restoring the cemetery to a dignified and respectful condition. Little did they know, that in that moment of commitment, they would be taking on one of the most healing and empowering projects with the consumers throughout the state. The Consumer Council, with the Georgia Mental Health Consumer Network, raised the funds, provided the direction and, ultimately saw to completion, the restoration of the cemetery. All of this culminated in October 2001, with the dedication of the memorial and the unveiling of a commissioned statue of a bronze angel symbolically lifting up the spirit of all those buried there. It is in this spirit that all the growth and development of Peer Support in Georgia has occurred.

Interestingly enough, it was during the same years of the Cemetery Restoration Project that another key milestone was achieved. In 1999 the first consumer operated Peer Centers were established. It makes perfect sense that while the consumers of Georgia were working toward such an empowering goal as the restoration of the Milledgeville cemetery, they would also be moved toward having greater influence and impact on the various models of treatment that were available to them.

Consumers *knew* that impact of informal peer support. You know, the kind that happens outside on the porch, or in between groups, or in the evening when you call a friend who "knows." Now consumers wanted that same powerful support to be available in accessible, meaningful ways that broaden the continuum of care offered by traditional models. They also knew that Recovery had to be a key ingredient of any systems change.

The Medicaid Peer Supports Model

In 1999, the Georgia Consumer Council adopted a list of values to guide the development of Peer Supports which would lead to these services being Medicaid reimbursable and encourage the development of consumer operated Peer Centers, that would become a new service provider category. With permission, the list is included here:

- Peer Supports must be part of a wrap-around continuum of services in conjunction with other community mental health services.
- Peer Support programs must not be clinical. The only type of counseling should be peer counseling.
- Must be completely staffed by consumers who serve as role models. These staff members must be willing to openly share their stories of recovery and willing to share tools they have used to succeed. Yet they must be willing to learn from others.
- Peer Support programs must be individualized to the consumer.
- There must be other services available to handle crises and medical needs that are not a part of Peer Supports.
- Programs must promote socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

- Groups in peer support services must be on an equal level – not in the teacher/student model. The facilitation of a majority of the groups will come from the attendees, not the staff, in order to promote leadership within the community. Peer staff is there to guide, not direct.
- Consumers must be encouraged to strengthen their independence. Therefore, peer staff will support consumers in making their own decisions, not make them for the consumers. Staff's role is to help the consumer meet his or her goals through encouragement to self-advocate.
- Groups should be individualized. There should be adequate space to allow for several groups to meet at the same time. All consumers do not need to be in the same groups; for example, consumers should attend substance abuse groups only if they need to address that issue.
- There will be committees comprised of the attendees that are involved, along with staff, in the decision making process of running this service. These committees must address issues such as daily schedule, activities, policy and procedures, grievances, fund raising, and task assignments.

While not all of these values have been actualized in service delivery, the evolution of Georgia's Peer Supports has made continuous strides in that direction. Current guidelines for Peer Supports state that this service provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and main-tenance of community living skills under the direct supervision of a mental health professional. A consumer peer Support Center maintains adequate staff support to enable a safe, structured environment in which consumers can meet and provide mutual support. Services are geared toward consumers with severe and persistent mental illness. These consumers may be dually diagnosed.

Typically, this service will operate during day/evening/weekend hours near public transportation or access to transportation services. A Peer Supports service must be operated for no less than twelve (12) hours a week, no less than four (4) hours per day, no less than three (3) days per week.

Consumers actively participate in decision-making and the operation of the programmatic supports. There will be scheduled activities that may include: meals and snacks, art and other recreational/leisure activities, educational seminars, informal and formal peer support meetings, and planning/feedback committees. The service promotes socialization, recovery, self-sufficiency, self-advocacy, the development of natural supports and maintaining those skills learned in other support services.

The purpose of a Peer Supports service is to provide an opportunity for consumers to direct their own recovery and advocacy process and to teach and support each other in the acquisition and exercise of skills needed for management of symptoms and for utilization of natural resources within the community.

There are specific organizational components for Peer Supports to be Medicaid reimbursable.

1. A Peer Supports service may operate as:
    - a program within a freestanding Peer Center;
    - a program within an existing clinical service provider without a Peer Center;
    - a program within a Peer Center that is within a linical service provider; or
    - a program within a larger clinical or community human service provider administratively, (either with or without a Peer Center, but with complete programmatic autonomy).
2. A Peer Supports service must be operated for no less than twelve (12) hours a week, no less than four (4) hours per day, no less than three (3) days per week, typically during day, evening and weekend hours.
3. The governing board of a freestanding Peer Center must be composed of 75% consumers and represent the cultural diversity of the population of the community being served. The board is encouraged to have either board members or operating relationships with persons with legal and accounting expertise. For programs that are part of a larger organizational structure that is not consumer led and operated, the Peer Supports Program must have an advisory body with the same composition as for a freestanding Peer Center's board. The board or advisory committee must have the ability to develop programmatic descriptions and guidelines (consistent with state and federal regulations, accreditation requirements, and sponsoring agency operating policies), review and comment on the Peer Support Program's budgets, review activity offerings, and participate in dispute resolution activities for the program.
4. Consumers participating in the service at any given time must be given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, and about the schedule of those activities and services, as well as other operational issues.
5. Regardless of organizational structure, the service must be directed and led by consumers themselves.
6. Peer Supports may include meals or other social activities for purpose of building peer relationships, but meals should not be the central or core activity offered.

The focus of the service is skill maintenance and enhancement, and building individual consumer's capacity to advocate for themselves and other consumers.

7. Peer Supports should not be operated in isolation from the rest of the programs within the facility or organization with which it is affiliated. The Program Leader must be able to call multi-disciplinary team meetings regarding a participating consumer's needs and desires, and a Peer Specialist providing services for and with a participating consumer must be allowed to participate in multi-disciplinary team meetings.

There are specific staffing requirements for Peer Supports to be Medicaid reimbursable.

1. The program must be under the clinical supervision of a MHP, preferably a consumer who is a Georgia Certified Peer Specialist (CPS), and preferably who is credentialed by IAPSRS as a Certified Psychiatric Rehabilitation Professional (CPRP). *All* staff are encouraged to seek and obtain Georgia certification as a Peer Specialist and IAPSRS CPRP credentials.

2. The individual leading and managing the day-to-day operations of the program must be a Georgia CPS, who is a CPRP or can demonstrate activity toward attainment of CPRP registration or certification.

3. The Program Leader must be employed by the sponsoring agency at least 20 hours a week.

4. The Program Leader and CPS in the Peer Supports program may be shared with other programs so long as the Program Leader is able to be present no less than 75% of the hours the Peer Supports program is in operation, and so long as the Program Leader and the Georgia CPSs are available as required for supervision and clinical operations, and so long as they are not counted in consumer to staff ratios for two different programs operating at the same time.

5. Services must be provided and/or activities led by staff that are Georgia CPS's or other consumers, under the supervision of a CPS. A specific activity may be taught by persons who are not consumers but are invited guests.

6. There must be at least two Georgia CPSs on staff either in the Peer Supports Program or in a combination of Peer Supports and other programs and services operating within the agency.

7. There must be a maximum face-to-face ratio of an average of not more than thirty (30) consumers to one (1) CPS, based on average daily attendance of consumers in the program.
8. There must be a maximum face-to-face ratio of an average of not more than fifteen (15) consumers to one (1) direct service/program staff, based on the average daily attendance of consumers in the program.
9. All staff must have an understanding of recovery and psychosocial rehabilitation principles as defined by the Georgia Consumer Council and psychosocial rehabilitation principles published by IAPSRS and must possess the skills and ability to assist other consumers in their own recovery processes.

There are specific staffing requirements for Clinical Operations to be Medicaid reimbursable.

1. This service must operate at an established site approved to bill Medicaid for services. However, individual or group activities may take place off-site in natural community settings as is appropriate to the participating consumers' Individual Services Plans (ISPs) developed by each individual for him/herself, with assistance from the Program staff.

2. This service may operate in the same building as other day services; however, there must be a distinct separation between these services in staffing, program description, and physical space during the hours the Peer Supports program is in operation, except as provided above.

3. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order that services can be provided effectively and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for consumer use within the Peer Supports program must not be substantially different from space provided for other uses for similar numbers of individuals.

4. Staff of the Peer Supports Program must be treated as equal to any other staff of the facility or organization and must be provided equivalent opportunities for training (both mandated and offered) and pay and benefits that are competitive and comparable to other staff based on experience and skill level.

5. Weekly progress notes must document consumer progress relative to functioning and skills related to goals identified in his/her ISP.

6. Daily attendance of each consumer participating in the program must be documented for billing purposes.

7. When this service is used in conjunction with Psychosocial Rehabilitation, and ACT, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts. Utilization of this service in conjunction with these services will be subject to UM/UR review.

8. Each consumer should set his or her own individualized goals and assess his or her own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Implementation of services may take place individually or in groups.

9. Each consumer must be provided opportunity for peer assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals.

10. A Peer Supports program must offer a range of skill-building and recovery activities developed and led by consumers. These activities must include those that will most effectively support achievement of the individual consumer's rehabilitation and recovery goals.

11. The program must have a Peer Supports Organizational Plan addressing the following:

- A service philosophy reflecting recovery principles as articulated by the Georgia Consumer Council. This philosophy must be actively incorporated into all services and activities, e.g.:
  - ⇒ View each individual as the director of his/her rehabilitation and recovery process;
  - ⇒ Promote the value of self-help, peer support and personal empowerment to foster recovery;
  - ⇒ Promote information about mental illness and coping skills.
  - ⇒ Promote peer-to-peer training of individual skills, social skills, community/natural resources, and group and individual advocacy;
  - ⇒ Promote supported employment and education that fosters self-determination and career advancement,
  - ⇒ Support each consumer to "get a life" using natural occurring resources to replace the resources of the mental health system no longer needed.

⇒ Support each consumer to fully integrate into accepting communities in the least intrusive environment that promotes housing of his/her choice.
⇒ Actively seek ongoing consumer input into program and service content so as to meet each individual's needs and goals and foster the recovery process.

- A description of the particular consumer empowerment models utilized, types of activities offered, and typical daily curriculum and schedule; if offered, meals should be described as an adjunctive peer relationship building activity rather than as a central activity.

- A description of the staffing pattern, plans for staff who have or will achieve Peer Specialist and APRP credentials, and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated;

- A description of how consumer staff within the agency will be given opportunities to meet with or otherwise receive support from other consumers (including Georgia certified Peer Specialists) both within and outside the agency;

- A description of how consumers will be encouraged and supported to seek Georgia certification as a Peer Specialist, e.g., participation in training opportunities; peer or other counseling regarding anxiety about test-taking, assistance with study skills, information about training and testing opportunities, oppor-tunities to hear from and interact with consumers who are already certified, additional opportunities within the agency after certification, etc.

- A description of how the consumer staff will participate in clinical team meetings at the request of a consumer and the procedure for the Program Leader requesting a team meeting;

- A description of the hours of operation, the staff assigned, and the types of services and activities provided for and by consumers as well as for families, parents, and/or guardians;

- A description of the program's decision-making processes including how consumers direct decision-making about both individual and program-wide activities and about key policies and dispute resolution processes;

- A description of how consumers participating in the service at any given time will be given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports

program, and about the schedule of those activities and services, as well as other operational issues.

- A description of the space, furnishings, materials, supplies, transportation, and other resources available for consumers participating in the Peer Supports services; A description of the governing body and/or advisory structures indicating how this body/structure meets requirements for consumer leadership and cultural diversity;

- A description of how the plan for services and activities will be modified or adjusted to meet the needs specified in each consumer's ISP.

- A description of how consumer requests for discharge and change in services or service intensity are handled.

Development of a Peer Center

Here in Georgia, the consumer operated Peer Center, referred to in the state Medicaid guidelines as *Peer Support Centers*, have been around since 1999. With the implementation of The Rehab Option, these Peer Centers could operate as a special provider and only required to offer Peer Support services. All Peer Centers have fundamental principles from which they should operate. They should be 100% consumer staffed, be non-coercive in any way, rely on user participation to direct program goals and services, promote recovery and self-determination, and develop leadership from within the program. These core beliefs are instrumental in the development of Peer Center and also serve as a way to direct ongoing growth and development. When developing a Peer Center careful attention to Medicaid guidelines listed in the previous section must be considered in order for the program to bill for reimbursable services, but Peer Centers should also provide additional programming that may fall outside the realm of reimbursable services. In doing this, a Peer Center is able to capture some of the values proposed by the Georgia Consumer Council, which are not yet supported by Medicaid.

While all Peer Centers will share common beliefs, each Peer Center will look unique due to the needs and influences of its community and membership. One of the biggest considerations when developing a Peer Center is that of the larger community in which the program will operate. Is your community rural, urban, or suburban? Is there access to public transportation? Will you operate out of a stand-alone building or will you share space along side of traditional mental health

services? These are some of the questions that will determine the model you choose.

Here is an example of a Peer Center that operates as part of a Community Service Board (CSB) in DeKalb County, Georgia. Vivienne Pierce, a Certified Peer Specialist who works with the program, provides the following description:

Crossroads:
A Peer and Supported Employment Program

Crossroads first opened in November 1999. We were able to open because of the Medicaid Rehab Option that provides for reimbursable Peer Support services. When Crossroads first opened there was one peer specialist and three Supported Employment counselors. Our member-ship began with about seven to twelve consumers, total.

In February 2003, Crossroads had a census (total membership) of over 80 consumers. Our staff now consists of two Certified Peer Specialists, two full- time supported employment counselors, one part-time job development counselor, a full-time Case Manager, a Masters level Occupational Therapist and an on-site Psychiatrist who comes weekly.

The Crossroads philosophy says that people with mental illness can and do recover and lead fully productive lives, even if the mental illness persists within the person. Consumers can work, live independently and have meaningful relationships.

Within our program we offer several different ways to promote consumer leadership and ownership in our program. One aspect of our program is consumer-run groups. A few groups, which have been and are currently led by our key members, have been:

- The WRAP (Wellness Recovery Action Plan) Series
- Creative Expression Group - where members teach each other crafts and painting techniques
- Current Events Group - where members take turns researching and reporting the news

- Employment Support Group & Women's Support Group - where members take turns weekly leading a self-help group.

Another format within Crossroads that promotes ownership of our program and a feeling of self-responsibility are our various Committees. Some of our consumer-led Committees include: The Breakfast Club, where our members fix breakfast for the other members; The Event-Planning Committee, where members plan events like outings in the community, birthday celebrations and special events like guest speakers, talent shows and Open House for families; Welcoming Committee, where outreach is done and a warm organized welcome is planned for potential new members; Volunteering Committee, where planning is done for volunteering in the community; Newsletter Committee, where members create from top to bottom a regularly scheduled Crossroads newsletter; Advocacy Committee, where members travel within the state for advocacy-based meetings and conferences; and the Recreation Committee, where consumers set up basketball and volleyball teams and social events in the community.

The final way that Crossroads helps promote member leadership, along with improving pre-employment skills, is through our three Work-Units. They are the Administrative Unit, the Snack-bar Unit, and our Thrift Store. Our members mostly run these units with oversight from the Certified Peer-Specialists. These units help develop management skills, clerical skills, cash-register skills and some janitorial skills. Also important are the self-responsibility and "follow through" skills needed for paid employment.

Finally, there is the Supported Employment component of Crossroads. We offer three job-search type groups, two beginning groups and one more advanced group. These groups help teach members the various ways to look for a job, how to interview for a job, fill out applications and write resumes. Also included in Supported Employment is staff involvement with taking the consumer for a job search to potential job sites or to neighborhoods where the member would prefer to work. Our counselors continue to support the member once he or she has been hired by making on-site visits, maintaining a relationship with the member's employer, and advocating for the consumer when needed. Included within Supported Employment is the offering of two computer classes per week.

We believe that Crossroads is an *excellent* full-service recovery-oriented program. If you ask our members, you'll find that they agree!

An alternate model of a Peer Center is a private, for-profit provider that serves much of Southeast Georgia — a program called AmericanWork, Inc. This provider operates multiple sites in small towns, with each program being unique to the community it serves. The component that is consistent between all of the sites is a focus on vocational success for all of its members. This is made abundantly clear even in the name of the program— Amer-I-can-work!

AmericanWork, Inc. is owned by a consumer and staffed by consumers, several who are CPSs. The program utilizes wrap-around services to enhance its vocational focus. Supported Living, day services, Supported Employment, transportation support, and financial planning all serve to ensure that each consumer is employed as quickly as possible. The driving philosophy of AmericanWork is: *work first, recovery follows.*

These models do not represent an exclusive list of how Peer Centers should be realized. Rather, it is a representation of how Peer Centers can be similar in philosophy and different in structure. The above-cited programs are examples of successful Peer Centers from around the state making these various choices. What they have in common is a firm commitment to Recovery, are non-coercive, rely on user participation to direct program goals and services, the promotion of self-determination, and the development of leadership from within the program.

Georgia Peer Support Institute

In July 2002, the Office of Consumer Relations in the Division of Mental Health, Developmental Disabilities and Addictive Diseases created the Georgia Peer Support Institute (PSI). The Institute is funded by the State through a contract with the Georgia Mental Health Consumer Network.

The mission of the Institute is to identify, train, and support consumer leaders in Georgia who will promote and evaluate peer support services in their communities. Twice each year, the Institute selects 35 consumers to attend a three-day training program. Funding allows the Institute to cover the attendees' expenses, including lodging, meals, training materials and mileage. The two trainings are traditionally held in different parts of the state to accommodate travel needs.

The training is focused on the principles and concepts of recovery and how this differs from the medical model (clinic option), the creation of a self-help coping skills plan, supported employment and advocacy for increased peer support services throughout Georgia.

As its cornerstone, the PSI believes that peer support is key to consumer recovery. It also believes that consumers have the right to educate each other about what peer support is, what they should expect from peer support and how to access and influence peer support in their home community.

The Georgia Peer Support Institute was born out of the Georgia Consumer Leadership Institute, a program that began through a contract with the Georgia Mental Health Consumer Network and supportive funding from APS Healthcare, Inc. The goal of the Leadership Institute was to identify and support local consumer leaders. These consumer leaders were educated about stigma, the Surgeon General's Report of 2000, and various techniques to use to bring peer support and consumer leadership to the forefront. In 2002, a keener focus was introduced to meet the goals laid down by the consumers of Georgia to increase the presence and understanding of peer support to all consumers throughout the State. With this narrowing of focus came a new name.

Each Institute strives to teach the participants:

- What peer support is and how it promotes recovery.
- How to advocate for peer support projects in your community.
- All about Self-directed Recovery.
- How to create your own self-help coping skills plan.
- How to start and sustain self-help/mutual support groups.
- How Supported Employment promotes recovery, self-determination, and community living.

Consumers can make application to the Institute themselves, but recommendations are sought from Peer Center Directors, Certified Peer Specialists, Private Providers, and the staff of Regional Planning Boards and Community Service Boards. Attendees should be consumers with an interest in participating in the growth of peer services throughout the State. Every effort is made to have representation from all regions of the State.

Georgia Peer Specialist Certification Project

In December 2001 approximately 35 current and former consumers completed their training and examination to become Georgia's first class of Certified Peer Specialists (CPSs). As of February 2003 there were a total of 119 CPSs who filled key roles in the

public mental health system. Certified Peer Specialists are responsible for the implementation of peer support services, which are Medicaid reimbursable under Georgia's new Rehab Option. Certified Peer Specialists also serve on Assertive Community Treatment Teams (ACT) and on Community Support Teams (CST). A natural outgrowth of the 1999 Surgeon General's Report on Mental Health has been the realization of the value of peer-to-peer support in the acquisition of real recovery. Certified Peer Specialists provide hope and role model that possibility to every consumer they serve. As paid employees of our public and private providers, CPSs neatly transition ownership of the program into the hands of the con-sumers seeking services in peer support programs. The Peer Specialist Certification Project conducts ongoing training at least two times a year and holds quarterly continuing education seminars and workshops for those already certified and who are required to stay abreast of emerging best practices in mental health recovery.

A portion of the Georgia Peer Specialist Certification Project is funded through a grant from the Substance Abuse Mental Health Services Administration, Center for Mental Health Services. This federal grant is administered through the Georgia Mental Health Consumer Network, in collaboration with the State Office of Consumer Relations.

Key to the successful implementation of CPSs in service delivery roles in consumer operated Peer Centers, in Peer Supports, and on ACT and CST teams is the understanding of what creates recovery and how to build environments conducive to recovery in peer support services. This role is not interchangeable with traditional staff that usually works from the perspective of their training and or their status as licensed health care providers. Certified Peer Specialists work from the perspective of "having been there." They lend unique insight into mental illness and what makes recovery possible.

The training and certification process prepares CPSs to promote hope, personal responsibility, empowerment, education, and self-determination in the communities in which they serve. Certified Peer Specialists are part of the shift that is taking place in the Georgia Mental Health System from one that focuses on the individual's illness to one that focuses on the individual's strength. Recovery is no longer only about what clinicians do to consumers--it has become, with the assistance of CPSs, what consumers do for themselves and each other. Thus CPSs are trained to assist consumers in skills building, goal setting, problem solving, conducting Recovery Dialogues, setting up and sustaining mutual self-help groups, and in helping consumers build their own self-directed recovery tools including the WRAP. A critical role is supporting consumers in developing an ISP that has their recovery goals and specific steps to obtain to reach those goals. Further requirements of certification include understanding the structure

of the Georgia mental health system, client rights, cultural competency and APS Healthcare charting and confidentiality.

Consumers who are interested in becoming a Certified Peer Specialist make application through the Georgia Peer Specialist Certification Project manager. Candidates are selected for the training based on their employment status and the ability to meet the training guidelines. Consumers who are currently employed by a public or private provider of Medicaid billable services are highest priority. A consumer who has distinguished him/herself as a peer leader and is being sponsored by a Medicaid provider for possible hire is given next priority. Consumers who work within a peer service that does not bill Medicaid or a consumer that is seeking certification to improve their marketability are given subsequent priority. This system was devised to assist program providers in meeting the guidelines that have been set by Medicaid.

Candidates for Certification Training will…

- Identify themselves as former or current consumers of mental health or dual diagnosis services. Candidates must be well grounded in their own recovery experience for at least one year. Certification is not open to consumers exclusively diagnosed with addiction diseases.
- Hold a high school diploma or GED. Documentation may be requested.
- Take a pretest for reading comprehension and language composition.
- Demonstrate qualities of leadership, including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities.

In addition to attending the trainings, each participant must pass an exam that is offered about one month following the training. The exam includes both written and oral components. Following successful completion of the exam, and agreement to accept the Code of Ethics set out by the Georgia Peer Specialist Certification Project, the candidate officially becomes a Certified Peer Specialist.

The Certified Peer Specialist should be able to perform the following training outcomes that have been set by the Georgia Peer Specialist Certification Project:

- CPSs will be able to **identify** services and activities which promote recovery by instilling hope and experiences which lead to meaning and purpose, and which decrease stigma in the environments in which they serve.
- CPSs will be able to **articulate** points in their own recovery stories that are relevant to the obstacles faced by consumers of mental health services.
- CPSs will be able to **promote** personal responsibility for recovery as the individual consumer of mental health services defines recovery.

- CPSs will be able to **implement** recovery practices in the broad arena of the mental health service delivery system.

Once employed by a mental health service provider, a Certified Peer Specialist will have a specific job description that addresses the uniqueness of their position. However, there are some universal components to each CPSs job description (see Appendix B.). Some of the highlights of the job description are: CPSs provide peer support services; support consumers in recovery-based ISPs, serves as a consumer advocate; provides consumer information and peer support for consumers in a range of settings. The CPS performs a wide range of tasks to assist consumers in regaining control over their own lives and recovery process. The CPS will role model competency in recovery and ongoing coping skills.

Looking Forward

We, the Consumers of Georgia, have made great advances regarding Peer Services. We have much to be proud of. We are the first state in the nation to be able to bill for peer services under Medicaid Rehab Option. We have developed the first certification process in the nation for Peer Specialists. We have created an effective working relationship with the Division of Mental Health, Developmental Disabilities and Addictive Diseases. We have a hard working, statewide consumer-run organization. We have ongoing leadership training. We have claimed recovery as an indisputable right for all consumers. We are realizing a "revolution of vision." And, there is still plenty of work to be done.

If we use the key values identified by the Georgia Consumer Council as an indicator of progress and growth, we can see where some of the values have not yet been actualized. For instance, many consumer operated Peer Centers are not 100% consumer staffed. A barrier to achieving this has been the requirement of a Mental Health Professional (MHP) to oversee all programming. A subtler obstacle lies in convincing traditional staff that we, as consumers, are capable of over-site of our own Peer Services.

It is important that we continue to advocate for improved person-centered, recovery-based services in every treatment program. We need to develop more consumer operated Peer Centers, with at least one in every region of the state. We need to continue to educate "traditional staff" on developing environments that are conducive to Recovery. We need increased support for incorporating Supported Employment as a Medicaid Reimbursable service. There needs to be recognition of work as a vital component to recovery.

We need to lead the cause for reaching out to the consumers who are underserved. There should be efforts to identify those of us who are homeless, hidden, or hopeless. Our efforts as advocates need to embrace political and social change. We need to find a way for all our voices to be heard.

We need more consumer leaders at every level of mental health provision. Constant nurturing of new leaders must be a priority. We must insist on significant representation by consumers on Regional Planning Boards and Community Service Boards. Consumer operated Peer Centers and Peer Services need to create governing boards and/or advisory boards, which must have a composition of being at least 75% consumer-led.

By following our identified value statements and continuing our excellent history of partnering with traditional providers, advocates, and state planners, we will be able to achieve increased self-sufficiency, greater independence and more opportunity for Recovery. As exemplified by the Cemetery Restoration Project, we can see where our success has always been a result of working from a positive perspective when advocating for change.

> *Looking back, we can credit much of the success to taking the high moral ground and promoting a positive message that was not about blame or finger pointing … [it's] about restoring dignity and respect, not about attacking others … Georgia's consumers set off on a positive journey that demonstrated deep resolve and hard work. Along the way, that quiet "can-do" attitude became a magnet for others to jump in and help serve a greater purpose.*
>
> Larry Fricks
> In the introduction to *The Georgia Story: How to Successfully Restore a State Hospital Cemetery*

Key Words & Phrases

Appendix A

Appendix B

Appendix C

References & Bibliography

Key Words and Phrases

Advocate: a person who pleads another's cause, a person who speaks or writes in support of something.

APS Healthcare: a national organization that contracts to provide Georgia's external review of Medicaid compliance.

Assertive Community Treatment: an intensive community based service team comprised of various professionals including a CPS.

Best Practices: a designation given to services that prove to be effective and worthy of replication.

Cemetery Restoration Project: a 5-year project of the Georgia Consumer Council that improved the condition of the cemeteries at Central State Hospital.

Certified Peer Specialist: a designation earned by consumers who provide services in the mental health system.

Clinic Option: A Medicaid reimbursement program that preceded the Rehabilitation Option. Closely aligned with the Medical Model. This option required consumers to go to a clinic to receive Medicaid billable services.

Consumer: the term used to reference persons who have or do receive mental health services. Previous terms used included: patient or client; also used when referring to people involved in Addictive Disease and Developmental Disability services.

CPS: (see Certified Peer Specialist)

Department of Human Resources: the section of Georgia state government that is responsible for all state delivered programs that are service related, i.e.: Division of Family and Children Services and Division of Mental Health, Development Disa-bilities and Addictive Diseases.

DHR: see Department of Human Resources.

Disclose: to reveal or make known; as in, I choose to *disclose* my mental illness.

Division of Mental Health, Development Disabilities and Addictive Diseases: the section of DHR that is responsible for policy, planning and contracting of all public services throughout the state.

Drop-in Center: a level of service that focuses on social skills development and support, in a less structured manner.

ERO: see External Review Organization.

Evidenced-based Practices: a way of statistically proving the effectiveness of services.

External Review Organization: an agency that provides unbiased oversight of Medicaid reimbursable services to ensure appropriate services are being delivered.

Georgia Mental Health Consumer Network: a non-profit, statewide, consumer-lead organization that represents consumers in advancement of quality programming and advocacy.

Georgia Peer Specialist Certification Project: the initiative that provides training and support to consumers who are seeking to become certified.

Georgia Peer Support Institute: provides education to consumers regarding innovative peer support initiatives.

GMHCN: see Georgia Mental Health Consumer Network.

GPSCP: see Georgia Peer Specialist Certification Project.

GPSI: see Georgia Peer Support Institute.

IAPSRS: International Association of Psy-chiatric Rehabilitation Services.

Initiative: the action of taking the first step or move; responsibility for beginning or originating.

Individualized Service/Recovery Plan: a model of treatment planning that is used in TRIGRS (see below); Reliant on consumer wishes and goals.

Intervention: (component of ISP) the action that service provider will take in support of meeting the objective and goal.

ISP: see Individualized Service/Recovery Plan.

Medicaid Rehab Option: a model under which certain services can be billed and reimbursed that supports recovery.

Medical Model: an approach to service delivery that focuses on symptom management rather than on recovery.

Mental Health Professional: a broad category of various disciplines, all who meet provider guidelines for supervision and over-site of mental health services.

MHDDAD: see Division of Mental Health, Developmental Disabilities and Addictive Disease.

MHP: see Mental Health Professional.

Natural Supports: supports that occur within the larger community; not a part of mental health services. i.e., church, AA, clubs.

Office of Consumer Relations: a section in the Division of MHDDAD that ensures consumer representation at all levels of planning and policymaking.

Outcomes: results, used to discuss Evidence-based Practices.

Peer Center: A Medicaid category of program providership, frequently providing peer support services. Staffed and run by consumers.

Peer Services: *1* a category of approved Medicaid reimbursable services *2* a generic reference to any service that is provided by a consumer.

Peer Specialist: see Certified Peer Specialist, also a consumer who is working in the mental health system who has not earned certification.

Peer Specialist Certification Project: see Georgia Peer Specialist Certification Project.

Peer Support: see Peer Services

Peer Support Center: a category of program providing Peer Services.

PSR: see psychiatric rehabilitation.

Psychiatric Rehabilitation: a model of program that operates from guidelines established by IAPSRS; aka Psychosocial Rehab (PSR).

Recovery: *1* a regaining of something lost *2* a value that reinforces mental illness is a temporary condition.

Recovery Model: model based on the belief that people can and do recover from mental illness, important belief that influences the Rehab Option.

Rehab Option: see Medicaid Rehab Option.

Rehabilitation Option: see Medicaid Rehab Option.

Self-directed Recovery: belief that consumers are the leader of their treatment and recovery.

Stabilization: to make firm, to keep from fluctuating; as in symptom stabilization.

Symptom: any condition accompanying or resulting from an illness or disease and serving as an aid in diagnosis.

Treatment Planning: a strategic course of action that directs appropriate services and ensures Recovery.

Treatment Team: the composition of people who facilitate Recovery; the consumer, doctor, CPS, Case Manager and/or others who are specified in the Treatment Plan.

TRIGRS: (pronounced "triggers") Treatment Request and Integrated Georgia Reporting Survey.

UR: see Utilization Review

Utilization Review: a process to ensure a consumer is served appropriately.

Wrap-around: as in continuum of services, services that take into account the physical, mental, spiritual, and environmental needs of a consumer

Appendix A

Individual Service/ Recovery Plan

To view the ISP Form, please go to

http://www.apshealthcare.com/publicprograms/georgia/georgia.htm

Appendix B

Certified Peer Specialist Job Description

Georgia Certified Peer Specialist
Job Description, Responsibilities, Standards and Qualifications

Under immediate to general supervision, the Certified Peer Specialist (CPS) provides peer support services; serves as a consumer advocate; provides consumer information and peer support for consumers in emergency, outpatient or inpatient settings. The CPS performs a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. The CPS will role model competency in recovery and ongoing coping skills.

1. Using the 10-step goal setting process the CPS will:
   a. Assist consumers in articulating personal goals for recovery.
   b. Assist consumer in determining the objectives the consumer needs to take in order to reach his or her recovery goals.

2. The CPS will document the following on the Individual Service Plan (ISP) by:
   a. Assisting consumers in determining "Problems."
   b. Assisting consumers in identifying recovery goals.
   c. Assisting consumers in setting objectives.
   d. Determining interventions based on consumers recovery/life goals.
   e. Observing progress consumers make toward meeting objectives.
   f. Understanding and utilizing specific interventions necessary to assist consumers in meeting their recovery goals.

3. Utilizing the CPS' specific training the CPS will:
   a. Lead as well as teach consumers how to facilitate Recovery Dialogues by utilizing the Focus Conversation and Workshop methods.
   b. Assist consumers in setting up and sustaining self-help (mutual support) groups.
   c. Assist consumers in creating a Wellness Recovery Action Plan (WRAP).
   d. Utilize and teach problem solving techniques with individuals and groups.
   e. Teach consumers how to identify and combat negative self-talk.
   f. Teach consumers how to identify and overcome fears.
   g. Support the vocational choices consumers make and assist them in overcoming job-related anxiety.
   h. Assist consumers in building social skills in the community that will enhance job acquisition and tenure.
   i. Assist non-consumer staff in identifying program environments that are conducive to recovery; lend their unique insight into mental illness and what makes recovery possible.

j. Attend treatment team meetings to promote consumer use of self-directed recovery tools.

4. Utilizing their unique recovery experience the CPSs will:
   a. Teach and role model the value of every individual's recovery experience.
   b. Assist the consumer in obtaining decent and affordable housing of his or her choice in the most integrated, independent, and least intrusive or restrictive environment.
   c. Model effective coping techniques and self-help strategies.

5. Maintain a working knowledge of current trends and developments in the mental health field by reading books, journals and other relavent material.
   a. Continue to develop and share recovery-oriented material with other CPSs at the continuing education assemblies and on the CPS electronic bulletin board.
   b. Attend continuing education assemblies when offered by the CPS Project.
   c. Attend relevant seminars, meetings, and in-service trainings whenever offered.

6. Serve as a recovery agent by:
   a. Providing and advocating for effective recovery based services.
   b. Assist consumers in obtaining services that suit that individual's recovery needs.
   c. Inform consumers about community and natural supports and how to utilize these in the recovery process.
   d. Assist consumers in developing empowerment skill through self-advocacy and stigm-busting.

Appendix C

Resources and Contact Information / Georgia

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229-639-0477

Crossroads (Dekalb CSB)
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Atlanta GA 30317
404-378-6036

The Peer Project
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4840 Roswell Road, Suite C-100
Atlanta GA 30342
404-847-9927
thepeerproject@bellsouth.net

National Organizations that provide technical assistance.

Consumer Organization and Networking Technical Assistance Center (CONTAC)
1036 Quarrier Street
Charleston WV 25301
1 (888) 825-TECH (8324) or www.contac.org

CONTAC is a resource center for consumer/survivors/ex-patients and consumer-run organizations across the United States. Its website provides extensive links and information on how to contact consumer-run organizations.

National Empowerment Center
599 Canal Street, 5 East
Lawrence MA 01840
1 (800) power2u or www.nec.org

A consumer-run organization providing networking and coalition building, a national directory of mutual support groups, drop-in centers, and statewide organizations, and education and training to providers from a consumer/survivor perspective.

National Mental Health Consumers' Self-Help Clearinghouse
1211 Chestnut St., Suite 1000
Philadelphia PA 19107
1 (800) 553-4539 or www.libertynet.org/~mha/cl_house.html

A national technical assistance center serving the mental health consumer movement, helping to connect individuals to self-help and advocacy resources, offering expertise to self-help groups and peer-run services.

KEN – Knowledge Exchange Network
P.O. Box 42490
Washington DC 20015
1 (800) 789-2647 or www.mentalhealth.org

Developed by the Center for Mental Health Services, KEN provides information for users of mental health services and their families, the general public, policymakers, providers, and the media.

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